William Osler Health Centre P3 Commentary on Value for Money Benchmark and Letters of Assurance

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Overview: This note comments on several documents that are intended to provide assurance the decision to construct a new William Osler Hospital (WOHC) as a public-private partnership (P3) costs less than a public sector comparator. This assessment was prepared on behalf of the Ontario Public Service Employees Union, the Service Employees International Union, the Ontario Council of Hospital Unions, and the Ontario Health Coalition.

Overall Conclusion: The decision process and documents that I have reviewed have only increased my concern that the P3 arrangement for WOHC may be much poorer value for money than a comparable project with public financing and operation.

Background: In late 2002, the Ontario Ministry of Health and Long Term Care (MOHLTC) announced that it had approved two new hospital projects for the Royal Ottawa Hospital (ROH) and WOHC hospitals. These projects were to proceed by way of public-private partnerships (P3s) whereby the private sector would design, finance, build and operate new hospital facilities, and also provide non-clinical hospital services pursuant to a long term contracts lasting for more than 25 years in the case of the WOHC, and more than 66 years in the case of the ROH.

There were a number of reasons why this model was considered to be attractive by the governments involved. One is that it eliminated the need for the MOHLTC and/or the WOHC to directly borrow for these new hospital developments. Instead a private partner would obtain financing, at an estimated 1.35% premium in the case of WOHC, to the prime rate, for the hundreds of millions of dollars required for construction, and would bundle up into one overall contract both the hospital construction and non-clinical services over the 25 year life of the contract. A Funding Agreement between the Hospital and the Ministry would set out the respective obligations of the Ministry and the Hospital with respect to the payments required by the Project Agreement.

The P3 model represented an unprecedented departure from the traditional model for funding and operating public hospitals in Ontario whereby the public sector borrowed the money to pay the private sector to build the hospital, and also operated the hospital,

sometimes with contracts to the private sector for specified services. The province's own rules required the Ministry to demonstrate that the P3 arrangements represented reasonable value for the over billion dollars in public funding that would be committed to these schemes.

The Value for Money Benchmark: To ensure the validity of the P3 scheme, WOHC prepared a Value for Money Benchmark (VFMB) to estimate the costs of establishing the hospital infrastructure and providing non-clinical operating services in the conventional model of public funding, and not for profit delivery. The P3 proposals would then be compared against the VFMB and each other.

The purpose of the VFMB was to give decision-makers a valid comparison that would show whether the P3 arrangement was superior to a public sector financing and control of non clinical operations. The VFMB is expressed as a range since many components can only be estimated. In WOHC's calculation, the range was +/- 7.5% -- about $100 million either way.

Of course, in order for this to be a credible and accurate exercise, it is important that the VFMB truly reflect public sector costs. One of many obstacles to correctly designing and calculating a VFMB is that the costs of self insurance (that is risk transfer) against various kinds of risks can be seriously overestimated. Another can be the use of an unrealistically high discount rate, which when converted into current dollars, makes the large future payments to a bidder much smaller in comparison. This makes loading large payments closer to the end of the project appear more palatable when making the comparison.

Deloitte and Touche review of the VFMB: To ensure a credible VFMB, due diligence is required. Typically due diligence involves the commissioning of independent assessments by reputable firms. Perhaps the most important part of this process was the independent assessment by Deloitte and Touche of the VFMB prepared by WOHC. This review took place during the spring and summer of 2003. It was not intended to be a formal letter of assurance, but rather a review that would lead to a revised, if necessary VFMB, followed by such an assurance letter.

VFMB almost certainly too high and could not be fully verified: Deloitte's review was impressive in terms of its quality, critical stance, and thoroughness. I have seen no documents that question its quality or conclusions. While it was carefully couched in neutral terms, it presented a lengthy catalogue of deficiencies and errors of the VFMB, which clearly suggested – although it did not say so explicitly -- that the methodology used to derive the VFMB produced a result that was much too high and should be significantly lower. In other words, the Deloitte criticisms, if accepted, could lead one to conclude that it was quite likely that the P3 would cost more than the VFMB, rather than less. To try to get a more accurate number, Deloitte also asked Osler for data that would justify the methodology WOHC employed.

Changes and relevant information needed to improve the VFMB not provided: The Ministry and Osler did not accept most of the changes suggested by D&T's assessment, nor is there any evidence that they made available information requested by D&T to complete their assessment. If this information had been made available, and if the Ministry had not ignored most of the defects pointed out in the D&T review, the province and WOHC would have had to acknowledge that the public sector comparator using the conventional approach of public funding and not-for-profit delivery was significantly less expensive than the proposed P3 scheme. My calculation was that WOHC overstated the costs of the VFMB by at least $300 million and perhaps more than $400 million. A key reason was that the methodology employed by the WOHC to estimate benchmark costs for the delivery of non-clinical operating services - by far the single largest component of the VFMB – was inappropriate and unsupported. The reason this is so significant is that, as pointed out below, alleged savings on non clinical services are where essentially all the savings of the P3 are. All other costs were acknowledged to be similar or higher in the successful bid. But when added up, the bid overall appeared lower than the (overestimated) VFMB.

A year later, the successful (and only) bidder, THICC, wished to increase the bid to a higher value because of increased construction costs. The cost increases were sufficiently high that design changes were required to reduce them. Presumably, the government and the hospital would still want to be assured, or at least demonstrate that assurance was provided, that the new higher costs were justifiable, that services promised and needed were not compromised, and costs were still lower than the public sector comparator.

Letters of assurances from competent professionals about VFMB and related issues not very assuring: I reviewed the revised Value for Money Benchmark (VFMB) assurance letter and related confidential attachments dated January 31, 2005 from Deloitte and Touche that provided Deloitte's assurance opinion that the revised "bid remains below the VFMB range". This letter was part of the due diligence involved with agreeing to the request by the Healthcare Infrastructure Company of Canada (THICC), the successful bidder, for increased funds in the Construction Cost Escalation Variation process.

Reduced to its essence, Deloitte's 2005 assurance letter actually says only that if one trusts the numbers provided by WOHC and uses these numbers in the financial model developed for the project, then the bid remains lower than the VFMB. But why should one trust the numbers or the model? Deloitte gives us no reason to do so. They simply have accepted it on faith. While this letter apparently provided sufficient assurance to the Ministry and Osler that the project would cost less than a public sector comparator, there are good reasons to conclude otherwise. The first is that there is no evidence that the Ministry or WOHC took into account many of Deloitte's suggestions of the previous year, or bothered to justify why if in fact it disagreed with them. Nor is any reason given for not giving Deloitte the information it requested so that it could complete the excellent, but incomplete, analysis it performed in 2003.

As already observed above, a particularly noteworthy aspect of the comparison of the successful THICC bid to the VFMB is that practically all the savings for the P3 are on non clinical operating services. There are no significant savings, indeed there are some higher projected additional costs, with respect to the rest of the project, primarily the design and construction of the hospital. However, non clinical services in the VFMB totalled $820.3 million compared to the bid of $579.3 million. This enormous difference and projected lower cost of $241.5 million essentially says that the operating expenses, including profit and management fees of a privately run facility WOHC will be just 70% of a publicly run one. This is an utterly implausibly large saving, but is clearly consistent with the inference drawn from Deloitte's 2003 work that the VFMB is too high, perhaps $300 million.

Other figures in the financial model also cause concern, from the perspective of trying to determine whether private financing and governance, is more or less expensive, and accountable than public financing and operation.

P3 projects a good return on investment: The total figure for revenues over the life of the contract is projected at $2.74 billion. This does not include any allowance for retail space revenue, although apparently such revenue is contemplated and presumably may flow, at least in part, to the private sector partner. There is a net positive projected cash flow of $299.5 million over the course of the contract, which does not include a management fee relating to operating the hospital of $37.8 million. This cash flow goes to pay dividends. It is projected that the equity partners for the design, construction and financing of the building will receive $240.6 million in equity dividends on an equity investment of $61.1 million in addition to a return of equity. Equity dividends to "Project Co" (the operating company) are projected at $58.9 million plus return of capital over the life of the contract, on an equity investment of $21.5 million. There is $443.6 million of interest expense, of which about $94 million is above what would have been paid by a public borrower.

This means that without any allowance for refinancing, or additional profits, that this arrangement anticipates that even after dividends, additional interest, and management fees totalling about $430 million over the life of the project, there will, however implausibly, still be savings over a public sector comparator.

P3 financial model projects that few taxes to be paid: There are other issues as well. The biggest change made to the VFMB by WOHC after 2003 was to lower the "competitive parity adjustment", which is essentially an adjustment to reflect the fact that a public sector operator does not pay taxes. Originally this was $187 million. In the revised VFMB, this figure is $7 million, reflecting that THICC did not anticipate that it will pay any significant amount of taxes. In other words, despite all the fees, dividends,

and higher rates of interest that will be paid to the hospital operators, the investors and proponents are expected to pay very little extra in taxes than would have been paid had the hospital remained publicly financed and operated. In other words, the public sector does not even get the benefit of receiving taxes on the profits.

Incentives to minimize capital maintenance costs as the contract end date approaches built into the model: Another problematic, but significant assumption in the financial model and the VFMB is that at the end of the period that the hospital is worthless when it is transferred back to public ownership. This unfortunately is completely consistent with my concern that there will be significant incentives to spend as little as possible on capital maintenance as the contract term comes closer to the end just at the time when the need for capital maintenance will be increasing. No doubt the contract itself attempts to deal with this incentive problem, but whether it will be effective is a matter that will not be known for many years.

Revised project design reduces both space and flexibility: To control escalating costs from going even higher, the project design was changed. WOHC obtained various assurances that these changes will not negatively affect the functional requirements of the total project, that the VFMB is still comparable to the scope of the successful bid, that the VFMB was comparable to the scope of the successful bid, and that the bid is lower. However none of these assurances is particularly reassuring.

For example, several program elements, particularly administrative/support functions, will now be located off site. Parkin Architects noted in its assurance letter that relocation of program elements off site will produce "obvious capital cost savings." Rather than say that this will improve operations (which it probably will not), they opined that this is "reflective of current health planning". In other words, they said, somewhat circularly, that the design changes are consistent with the planners' design changes. They actually made no comment whatever on the potential negative – or positive -- impact of this change on hospital operations. It is possible that they might believe there will be no negative impact, but their letter did not say they believe this, or that they have any evidence-based reasoning that this will be the case. Had they done so, this would indeed have been reassuring.

There will also be space reductions. Agnew Peckham gave an assurance opinion that the design changes and space reductions will not negatively affect the functional requirements of the total project. Their opinion was that "in general" the changes do not "significantly" affect the requirements, but that there are "some notable exceptions." In other words, there is a negative impact that the consultants did not consider highly material for the most part, with two specified exceptions.

In the revised design, "Transition Beds will not be designed to afford all the flexibility specified by the Requirements". One impact of the reduced flexibility is that there will have to be a lower number of beds in a future medical/surgical unit than was originally planned.

Secondly, with respect to medical/surgical inpatient units, the original plan called for a pairing of two blocks of 37-38 beds. This allowed for the possibility to reallocate units over time, and to share some resources and to have cross staff coverage. However these blocks will now not be paired, which clearly will limit flexibility in the future. Agnew and Peckham noted, in defence of this negative impact, that WOHC staff have "reviewed and approved the proposed re-configuration of beds." They did not say they agreed with WOHC's conclusions, only that they accepted them. They did not say why.

Whether these sorts of negative impacts and others will continue as the project matures is not known. However, there is no reason to think that there will not always be these sorts of pressures, since dollars saved in expenditures, even if they reduce the ability to provide flexible and efficient care, are dollars that can be distributed as dividends to the equity investors of HICC. Escalating costs and reduced facilities even before the hospital opens is not an auspicious beginning for a long term partnership.

Reassurance that VFMB reflects the scope of the project comes from a firm with a declared conflict of interest. In addition to Deloitte's 2004 opinion that the bid is lower than the VFMB, Price Waterhouse Coopers provided a further assurance opinion that the VFMB was still comparable to the scope of the altered successful bid, and that the bid remained lower. They are clearly knowledgeable about the model, but there is a potential conflict of interest. The problem is their dual role of both assisting the proponents and then providing an opinion on their own work, since, as they, point out, they helped WOHC develop the VFMB. While it would be interesting to know their views and reactions, they do not refer at all to the critique of the VFMB prepared by Deloitte. Another limitation is that they accepted without audit and simply relied on the financial model prepared by THICC, for their conclusion that the P3 is a lower cost alternative,

Another assurance opinion, on the financial model itself, was obtained from Ernst and Young. [This letter dated November 22, 2004 and labelled private and confidential says that the model is appropriately constructed, reflects the key assumptions, is consistent with tax legislation, is logically consistent, and achieves the objectives desired.] This opinion however, had a number of significant caveats: Ernst and Young were not engaged to check if the model was consistent with the project and financing agreements, nor to assess the validity of underlying assumptions, nor commercial risks. So, for example, the agreement might actually permit a greater or lesser payment than contemplated in the model. In terms of the documents I have seen, there was at no point an independent review of the project and funding agreements to assess the magnitude of these kinds of risks. And, as with the other assurance letters, and unlike the Deloitte paper of 2003, there is no questioning of the underlying assumptions.

Finally, to buttress the case for the increases in the bid due to inflation, Hanscomb Limited provides a letter of assurance using data from Statistics Canada showing that average year over year construction costs have increased from 4.4% in February 2004 to 7.8 % in August. This letter's credibility is reduced because it exaggerates the case by using the index for all of Canada, rather than the index for Toronto which is somewhat lower, for example 7.4% for August 2004 and 4.2% for the first quarter. Nor does

Hanscomb attempt to show that the construction cost of a hospital is comparable to that of a light factory or office building, which is the basis for the Stat Can survey. And while this may seem like a modest amount, an extra $10 or $20 million is a significant proportion of the planned dividends.

Conclusion: So far, the WOHC P3 has had cost increases, space decreases, flexibility decreases,– and all of this with little transparency in the various early stages of the project. Any large project is bound to have bumps and problems. However the decision process and documents that I have reviewed, have only increased my concern that the P3 arrangement for WOHC is much poorer value for money than a comparable project with public financing and operation. Indeed, the new Osler may not only cost more, it may also end up providing a lower level of service at the same time, particularly in the latter stages of the project.

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